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## Original

### CHOLERA INFANTUM.

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"About this time expect thunder storms," says the family almanac. In summer, especially during heated spells, expect to meet with severe cases of cholera infantum, or what I choose to regard as the malignant form of summer diarrhea. Hence a few words on this subject at this season are eminently in order. For many years I have been convinced that the prime factor in the causation of cholera infantum was the condition of severe heat during our summer season. This view has lately begun to grow in the minds of authorities, while I published in the Medical Record in 1880 an article outlining these ideas. My object in directing attention to this point at this time is highly practical, as it involves the question of the best treatment.

Certainly there are numerous other outlying influences, such as previous attacks of indigestion from improper food, or of diarrhea from decomposed food, so rendered by the action of germs and neglect in preparation, which reduce nutrition and consequently resistance to the depressing effect of heat.

But without the heated term and the lack of fresh air of our tenement, in large cities we would have no cholera infantum. By this is meant not every form of summer diarrhea, but more properly those cases followed by collapse and death.

I do not believe in calling every case of loose bowels in infants during the summer cholera infantum; nor even severe cases of summer diarrhea, though these undeniably will invite and often precede a genuine attack of cholera infantum.

Certainly the proper preparation and preservation of artificial infant food should under no circumstances be neglected in order to prevent an attack of cholera infantum; never-

theless breast-fed infants are frequently attacked with the disorder when in the very best condition, showing that the effect of high and long-continued temperature, with a large percentage of humidity is the prime cause. This is through the depressing or devitalizing influence exerted upon the cerebro-spinal nerve centres, at once interrupting normal processes of digestion and allowing the ordinary germs infesting the intestinal canal to manifest virulent action.

Upon these views I base the line of treatment, which experience has proven to be correct, viz., the use of cold in various ways, in other words, "keep the baby cool." Let the dress be cool, the surrounding air be cool, by going upon the water or in the shaded parks, or on the street in the early mornings, giving cool baths several times daily, plenty of cool (not ice) water to drink. Keep the sleeping apartments well ventilated, night as well as day. When artificial food is used keep it upon the ice until needed, when it should be warmed in the bottle.

When the attack occurs with frequent watery, projective stool, with high rectal temperature, restlessr ess, vomiting, thirst and collapse, irrigate the rectum with a decinormal salt solution (sodium chloride) at the ordinary temperature of the atmosphere until the return flow is perfectly clear of mucus or feces. Try to pass the soft rubber rectal tube, without any eyelet on the side, as far up the intestine as it will go without force; otherwise it will bend on itself and be expelled. The tube can be passed its full length, in spite of the knowledge that there are an indefinite number of sigmoid flexures in the rectum of the infant, by gentle and patient maneuvering of the tube while the stream of water is running.

I have mentioned the use of decinormal salt solution, which I consider has its advantages. First, it does not irritate nor denude normal mucous epithelium. Secondly, being rapidly absorbed it replenishes the loss of blood serum in the vascular circulation, and so prevents shock or collapse, and restores the conditions previously existing. Besides all this, which is in every way important, it reduces temperature, and if not carefully watched may act as suddenly in this manner as to itself cause a condition of congestion or collapse from cold. Hence it is wise to wrap a small blanket about the child immediately after the irrigation, which should not occupy more than 20 minutes' time. The mother should be warned that there is likely to be a large, watery evacuation from the bowels soon after the irrigation is completed.

As to internal medication, combined with such treatment, I do not place much stress. A few drops of whiskey can be given for a few hours and then stopped. A weak solution of bichloride of mercury, 1 to 4 or 6000, in doses of a teaspoonful every two hours, can be given. Where nervous symptoms are predominant chloral hydrate in small doses, or paregoric from three to five drops, can be given for several doses. All food should be stopped for the time being during the attack, and nothing but boiled water that has been cooled, or toast water or barley water that has been cooked over an hour should be given. As a matter of fact, a mixture of bismuth subnit. and mercury with chalk suspended in mucilage, sometimes with a few grains of sodium salicylate, is my favorite prescription. Where the results of too great loss of blood serum are decidedly marked in the prduction of great restlessness and tossing I find nothing equal to iron in restoring the abnormal condition of the blood formation. The potassio tartrate or some preparation of peptonate of iron will be found most eligible. The return to milk diet must be managed most carefully. Sterilized milk is perhaps the best to begin with or a whey where the function has been seriously injured. Small quantities is the rule, whatever is used, and by feeling one's way carefully for a day or so any good preparation of milk can then be continued. The simplest, and as good as any, is that modified and cooked in the double cooker, as set forth by me in the Clinical Recorder for July, 1897.

# APPENDICITIS AND PERITYPHILITIS IN CHILDREN, WITH REMARKS ON THE ETIOLOGY, DIAGNOSIS AND MEDICINAL TREATMENT OF SAME.

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The frequency with which the disease occurs in children has been observed by Demme, Matterstock, Baginsky, Oppolzer and a great many others. Thus, in the Children's Hospital at Bern out of 127 children 36 cases were pronounced perityphlitis; in nine of these coprostasis caused the disease. It is a well-known fact that males are more predisposed to this disease than females.

Fitz found out of a series of 247 cases of children and adults that 80 per cent. were males and 20 per cent. were females.

Matterstock is a series of 72 cases of children found the disease in 51 males (70 4-5 per cent.) and in 21 females (or 29 1-5 per cent.).

## ANATOMICAL POINTS.

According to Ransohoff,toward the end of fetal life the three ampullae or sacculi of the cecum are formed by development of the three longitudinal bands of muscular fibres, the taeniae coli by the enlargement of the right anterior sac; the conical shape of the cecum is changed to its later more tetragonal form. The apex is drawn more and more to the left, until at last it is close to the ileo-cecal junction. The appendix now lies on the posterior medial side of the cecum, partially concealed behind it.

Toft has studied the size of the appendix. In 35 specimens at the ninth month of fetal life, equivalent to the time of birth; the average length was 4 1-2 centimetres; the circumference at the upper funnel shaped portion was nine millimetres and at the lower cylindrical portion six millimetres. In children of 10 months the appendix was five centimetres long and 10 millimetres in circumference at the upper and eight millimetres at the lower portion. In the fourth year it was six centimetres long, ten millimetres in circumference, and in the seventh year it was seven centimetres long and 10 millimetres in circumference. In adults it is ten centimetres long and 13 millimetres in circumference. The appendix is comparatively longer and wider in children than in adults. The mucous mebrane of the cecum and appendix is analogous to that of the colon. This proves that the physiological action is one of absorption favoring inspiration of the fecal matter and the formation of former fecal concretions.

According to Gerlach the mucous membranes at the entrance of the appendix form a valve which is usually developed between the ages of 3 and 12 years.

Ransohoff found that this valve prevented injections from the cecum from entering the appendix, which it seems is in this way to a great extent protected from the invasion of small foreign bodies. A very important point is the relation of the peritoneum to the appendix and cecum. The appendix has an entire peritoneal covering and the mesentery (so-called mesenteriolum), the length of which determines the mobility of the appendix. One of the folds in the latter forms Luschka's ileo-cecal fossa. When extensive inflammation from within outward, with perforation at the appendix, takes place, then necessarily peritonitis must follow.

According to Ransohoff, quoted by C. Fenger (Keating), a retro-cecal intra-peritoneal inflammation and paratyphilitis is an anatomical impossibility, for any inflammation extending from within outward, rising from the cecum or appendix must cause intraperitoneal inflammation, and this is a peritonitis.

Kraussold describes the various positions in which he has located the appendix.

First. Behind the cecum and the

ileum on the right or lower side of the mesentery.

Second. He has found it along the right border of the ascending colon point upward.

Third. Down over the pelvic border, or extending from behind around the ileum at this junction with the cecum. This is of extreme importance in the diagnosis of a local appendicular peritonitis, and the most vital point worth noting is the change of location that the appendix assumes.

In his text book on diseases of children Professor Baginsky lays a special stress on traumatism as an etiological factor in this disease, and thus he believes that tossing children about, violent exercise, especially while turning, can cause this disease. While we recognize the fact that this disease is due to a local infection caused by micro-organisms, we must not lose sight of the fact that mechanical injury to the mucous surface of the appendix and cecum from hardened feces can cause this disease, by exciting a local inflammatory process.

Bossard states that drastic cathartics and emetics and enemata can cause this disease. This certainly must be modified, for where an ulcer pre-exists and is on the verge of perforation, or an undiagnosed, localized abscess exists, such condition will tend to be irritated by the three agents above mentioned. I do not believe, however, that they can cause this disease directly.

The primary lesion is rarely found in the cecum, more often in the appendix.

According to Bossard, every little semi-solid accumulation of feces in the appendix is not pathological. Intestinal catarrh has been quoted by some authors to have been a forerunner of appendicitis. It is not the province of this paper to go into the bacteriology of the disease further than to say that we know that by means of an invasion of micro-organisms, an acute infectious process is established, resulting in inflammation and suppuration. At times the disease can be controlled or modified so that the suppurative process is not reached. In other words we can frequently limit an appendicitis by proper treatment and anti-phlogistic remedies, so that the disease will remain not only localized, but quiescent.

Baginsky believes that spinal disease of the pelvic bones, including Psoas abscess, sometimes push themselves forward to the region of the cecum.

## SYMPTOMS.

Pain is one of the first symptoms, not only noticeable on palpation, but is frequently complained of in the region of the cecum if the child is old enough.

One of the earliest symptoms is vomiting. Frequently constipation.

Children seem to complain of periodical colicky pains which seem to appear spontaneously. The appendix can frequently be felt as a hard, thick cord (owing to its infiltrated condition), quite movable in the abdominal cavity. It lies about the height of the crest of the ileum anteriorly, about an inch from the umbilicus. It is necessary to palpate downward and inward. If this premonitory condition has been either neglected by the parents or overlooked by the attendant, or if the usual treatment has not been successful, then through irritation of the peritoneum, or through spreading of the inflammation, from the appendix to the surrounding peritoneum, and the result is a perityphlitis. When this latter condition exists we can frequently notice the pains more intensified, especially in the ileo-cecal region, or that region corresponding to the anterior superior spine of the ileum. The vomitings also increased. The stool is usually hard, and the bowels constipated. There is also difficulty in passing water. The abdomen is usually distended; the skin hot. The children usually appear very sick, and lie with their legs drawn up and thus relax the abdominal muscles. The pulse is small and increased in frequency. The radial artery appears narrowed. Careful inspection and palpation in the same region where the pain is concentrated will frequently reveal a localized exudation varying in size. All will now

depend on whether the exudation will be absorbed or whether a spontaneous rupture will distribute the infection and cause a general peritonitis. There is intense thirst in some cases, in others merely dryness of the tongue and lips. There is distinct anorexia. The temperature reaches from 101 to 105. The pulse rises usually before the pain, and is usually from 100 to 120. It is not a safe guide to rely on either the elevation of the temperature nor on the high pulse rate. In very young children the attack is ushered in with convulsions, whereas older children frequently have chills. Icterus with deep pigmentation of the skin and the conjunctival mucous membrane may occur but rarely. Diarrhea is rare, but frequently occurs. There is frequently such distinct retention of urine and pain in the region of the bladder and external genitals that we may be misled from the actual seat of the disease. Frequently the symptoms of typhoid fever are so well marked that it is well to note the characteristic Widal reaction in differentiating appendicitis.

If, however, the diagnosis is positive, and we can localize our tumor in the right ileo-cecal region, then the treatment is very simple, especially so if the exudation remains extra-peritoneal. Here usually the symptoms will abate in intensity, although fever will remain. Pus if positively diagnosticated, should be removed and it is, in fact, well to call a surgeon at once, when the tumor can be felt. It is not necessary in my opinion, to operate every case of appendicitis, since a great many of them are not malignant, but simply catarrhal. I refer only to the disease as I have found it in infants and children. It is well, however, to bear in mind that such distinguished pediatrists like Baginsky have reported cases in which the pus has found its way through the cecum, through the bladder and also the rectum. These are all non-operative cases.

### THE PROGNOSIS.

The prognosis is uniformly favorable in adhesive or plastic appendicular peritonitis, but since we know that such conditions, when dormant, can be easily rekindled, it is a good plan to keep patients that have suffered an attack of appendicitis months, and in some cases years, on a strict diet, and under careful observation. At times the slightest dietetic error may cause not only a renewed attack, but a fatal suppurative form of the disease.

### TREATMENT.

The first remedy which we should insist upon is rest in bed. Next, it is advisable to inquire into the condition of the bowels, and if constipation exists then a large enema consisting of several ounces of glycerine mixed with one or two pints of lukewarm water should be thrown into the colon slowly, to flush it and to remove hardened feces.

Some authors advise giving an enema of one or two ounces of sweet oil one-half hour before the large aqueous injection. Some other authors advise giving calomel and other cathartics by the mouth, but since we desire to give the inflamed portion of the intestine as much rest as possible it is not advisable to pursue this plan. An ice bag should be applied over the tender portion of the abdomen and left in situ night and day. The best drug is opium in the form of tincture of opium or the extract of opium. We need not despair even if the child has no evacuation from the bowels for a number of days. Some authors, like Baginsky, believe that eight days and longer will do no harm to have the child constipated.

If the temperature is very high and the child in a robust condition with extreme tenderness and pain in the ileo-cecal region, then a few leeches will do excellent service. A good plan to follow is not to irrigate the colon and rectum with an enema for several days after the fever and pain have subsided.

### LOCALLY.

The application of iodoform ointment or ichthyol ointment, mercurial ointment or

R—Tinct. gallae.
Tinct. iodin.

Equal parts to be applied locally with a camel's hair brush.

During the course of treatment, it is advisable to give very small quantities of ice cold milk, in fact, only a liquid diet, and this very sparingly; small quantities at a time.

In conclusion permit me to say that the great majority of children recover from appendicitis, and that the suppurative form so fatal in adult life is uncommon in children.

Where surgical interference is called for the same rules governing adult operations hold good in children. Personally I believe that we operate too much, rather than too little in this disease.

In his text book, on diseases of children Professor Baginsky lays stress on a large series of cases observed by him in the Children's Hospital, at Berlin, most of which were not influenced and some ending fatally after the operation. He, therefore, warns against too hasty surgical interference.

—187 Second avenue.

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## A QUESTION OF DIFFERENTIAL DIAGNOSIS, ESPECIALLY APPLIED TO THE DIFFERENTIAL DIAGNOSIS OF MULTIPLE NEURITIS AND LOCOMOTOR ATAXIA.

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There is no physician so eminent in his profession or so well versed in all its details that at times he does not commit mistakes in diagnosis. While this assertion may be applied more forcibly to the general practitioner the specialist is not exempt from making errors in his own particular line of work. The human system is so diversified in its organization, so complicated in its forces, each individual being in himself a microcosm embracing a multitude of details, that to the keenest mind the problems afforded by the want of that equilibrium which we call disease, and whose perfect harmony constitutes health, oftentimes lack perfect solution.

It is only by individual investigation in a multitude of diseases, by closely observing the infinite variety afforded in a contemplation of disease factors and studying the revelations of the autopsy table, as well as that infinitesimal world disclosed by the microscope, that the studious and discerning practitioner becomes the able and skilled diagnostician.

The highest powers of the mind are brought into action in ferreting out the causes of disease and successfully coping with their consequences. Herein lies one of the chief charms of the physician's life. To accurately mark out the limitations of an encroaching disease, to see, as with prophetic eye, especially in some forms of cardiac trouble what the ultimate outcome will be, is not only self-satisfying to our powers of observation, but is full payment for the sacrifices we have made in our studies.

We should all strive to cultivate accuracy in diagnosis, and not be contented with the superficial symptoms which, apparently slight in themselves, may mask a grave disease.

Our attention was forcibly directed to the necessity of an accurate diagnosis by the fact of a man being sent into our wards at St. Joseph's Hospital with a history of developing locomotor ataxia. The patient was a male, 50 years of age, laborer, with a well-defined alcoholic history. There was absolutely no specific lesion present, and no history of a chancre or gonorrheal infection. He was not a drunkard in the broad acceptation of the term, but had indulged daily in spirits, not so much though as to interfere with his occupation.

Two months before admission he had complained to his physician that his extremities "felt numb," and that he did not seem to have as much control over his legs as formerly, and now and then he tottered "as

if his body was too heavy to be supported by his feet."

He also noticed that the "morning vomit" which had troubled him for some months had grown worse. His vision was excellent.

On examination I found a fairly well-nourished man, of considerable muscular development and with good heart action. There was some tenderness over the epigastric region, with an inclination to vomit when the stomach was pressed upon. His liver was small and sensitive on pressure, no signs of jaundice being present, but as he was a whiskey drinker we did not expect to find this prominent symptom of certain liver disorders.

An ataxic gait was immediately discovered on walking, and the tremor which could only be seen upon close observation became well-marked as he attempted to walk. The characteristic foot-drop of alcoholism was in evidence. On testing for the patellar reflex it was found to be in evidence, but very much modified. Romberg's symptom was present. There was no "girdle" sensation. Now, these symptoms can be found well marked in two diseases, namely, tabes dorsalis and multiple neuritis. If the examiner is satisfied with these "findings" and pursues his investigations no further, in the majority of instances he will choose the more formidable complaint. Thus it was in this particular instance; guided by these few symptoms the diagnosis had been made and the patient informed that he was practically incurable. A closer investigation demonstrated the absence of the Argyll-Robertson sign, where the pupil contracts for accommodation, but is irresponsive to light, and which is invariably present, even at an early stage of locomotor ataxia; the bladder was not at all involved, either in the direction of incontinence or retention, and while undoubtedly there was pain, it was an acute tenderness, continuous in character and not partaking of those paroxysmal attacks which accompany the development of tabes. The history of the case also disclosed that the ataxia symptoms had manifested an acute development, while it is well-known in locomotor ataxia the loss of muscular strength is gradual.

A favorable prognosis was given based (1) upon the alcoholic history, (2) the presence of the foot-drop, (3) the absence of the Argyll-Robertson sign, (4) the acuteness of the attack, (5) the absence of sphincter involvement and (6) of the "girdle" symptom, and the patient made a tedious but sure recovery.

The favorable outcome of the majority of cases of multiple neuritis proves that no matter how extensive the paralysis caused by the inflammation and degeneration of the peripheral nerves the nerve centres are not involved. Its presence may often be due to the undermining influences of some miasmatic poison, as malaria, and to those who are peculiarly susceptible to malarial influences the disease develops with remarkable rapidity. But as in the latter disease arsenic is often used it frequently becomes a question whether the use of the drug is not an important factor in developing the disease. It occurs as an epidemic in Japan and South America under the name of beri-beri, or kakke. On the continent it has been described under the name of "acrodynia." There is a so-called "rheumatic" form, which on superficial examination would not be recognized as a neuritis, just as the incipient signs of tabes are often classed as manifestations of rheumatism.

There are sensory disturbances, numbness of the hands and feet, with tenderness of the soles, or perhaps of the whole extremities. But the symptoms of the disease are not necessarily confined to the lower portions of the body. The nerves of the face and eyes may be involved, and the patient be unable to help himself in any way. Many of the classic symptoms of locomotor ataxia are present as we have shown, but the "girdle" symptom is generally absent, though there may be slight involvement of the bladder from other causes, thus making the diagnosis more obscure.

Many a brilliant reputation has been established among the upper strata of society by a physician mak-

ing a diagnosis of locomotor ataxia and two months afterward curing a multiple neuritis of alcoholic origin.

There are at least two distinct types of neuritis, the interstitial and the parenchymatous. Clinically there may not be any absolute line between the two forms, only the interstitial is found predominating among conditions where rheumatic influences are prevalent. It is the parenchymatous which is found in multiple neuritis. In this form there may be involved only segments of the nerves, hence the term "segmental neuritis" is often applied.

Another patient, a female, aged 18, domestic, whose previous history had been excellent, was sent in as a neurasthenic. She was irritable, restless and unable to confine her attention, being recalled frequently to the subject in hand during conversation. She complained of tachycardia, her pulse averaging 132 to the minute. There was no exophthalmos, but there was found considerable enlargement of the thyroid. She was accordingly treated for the goitre, and the neurasthenic symptoms were quickly dissipated. The treatment of the two conditions is so entirely different that an accurate diagnosis should be established, and this cannot be done by a superficial examination of the pulse, where the rapidity is supposedly due to functional palpitation, or to the natural nervousness arising in the course of the examination.

A paper read at the June meeting of the Harlem Medical Society by Professor Manley on "Surgical Lesions of the Shoulder Joint," and in the after discussion of which the writer participated, gave rise to some interesting points in differential diagnosis viewed from a medical standpoint. One of the most common errors commited by the surgeon is to mistake a periarthritis, or any other disease which causes a mechanical impairment of the shoulder joint, for paralysis of the deltoid, the diagnosis being based upon the fact that the patient cannot raise the arm from the shoulder, together with an oftentimes marked wasting of the deltoid. The atrophy is due to the secondary effects of the joint disease, the condition being easily disclosed by passive motion. Where paralysis exists there is no obstacle to passive motion, but where the joint is involved by an inflammatory exudate there will be decided resistance. When periarthritis is present the patient may be able to raise his arm, however slightly; while the impairment due to paralysis of the deltoid is absolute.

In passing it might be mentioned that while tuberculosis may be found in any of the larger joints, I have never seen a case of tuberculosis of the shoulder joint, and my experience in the sphere of tubercular affections has not been limited.

There are many of the acute diseases which may as an after consequence develop some lesion of the shoulder joint. Thus, after typhoid or scarlatina, a neuritis may develop in the shoulder, which to the casual observer strikingly simulates poliomyelitis. There is great tenderness and wasting with rapid onset of all the symptoms, but in the etiology of the disease a favorable prognosis will be found.

Another common source of error is that in dislocations of the shoulder injuries to the brachial plexus are common, but the wasting and paralysis following such traumatic lesions are apt to be attributed to involvement of the spine.

Gonorrheal infection of a joint is very often mistaken for acute articular rheumatism. A case in point will aptly illustrate this statement. Some two months ago I was consulted by a girl, 16 years of age, residing at home, who complained excessively of pain in the left wrist. She informed me that she had undergone an attack of rheumatism a year ago, and ascribed her present condition to a recrudescence of her ancient enemy. Her modest appearance, her family surroundings, her age and the fact that she complained of some slight pain in her knees, compelled me to diagnose a rheumatic process. But when she returned in a few days with the wrist in the same condition, no improvement having followed the exhibition of the salicylates, and the joint, instead of being red from the acute development of

the rheumatic inflammation, was found blanched in appearance, I suspected the presence of the gonococcus. On closely questioning her this "demure little maiden" acknowledged with much bewailing her indulgence in the forbidden fruit, and a consequent change of treatment resulted in her recovery.

Mono-articular inflammation is generally indicative of gonorrheal infection, other causes being eliminated, in maiden or youth.

In the examination of patients in whom there is every reason to suspect a latent tuberculosis many errors from a diagnostic point are committed. The diagnosis of an incipient tubercular condition of the lungs in many cases is very difficult. There is apt to be so much bronchitis associated with the tubercular development as to mask the more serious malady, and require upon the part of the examining physician the most careful research. In the minds of most physicians there seems to exist the belief that if the focus of infection is not localized in the apex of the left lung a careful examination will not disclose its presence at other places. I have found a very favorite site for the localization of the incipient tubercular process to be between the scapulae, and more frequently a point lying midway to the right of the spinal column and that bone.

Upon a cursory examination this point of infection will not be found, as the muscles are thick, and even with deep percussion, nothing abnormal will be elicited, but if the patient is directed to place his right hand on his left shoulder, drawing the arm over the anterior portion of the chest, thus producing a tense condition of the thick muscular layer lying over the scapular region, the examiner will be able upon deep percussion and auscultation to readily find evidences of the disease if any are present. In cases of catarrhal phthisis the associated bronchitis frequently conceals the signs of consolidation, so that the diagnosis of phthisis is not generally made until the formation of a cavity has given rise to unmistakable cavernous sounds. The diagnosis of incipient pulmonary tuberculosis is one of the most difficult problems that can confront the physician, and its early recognition is of such great importance that the most careful, thorough and accurate examination should be given every patient whose personal or family history would lead one to suspect its presence. The earlier the diagnosis is made the better the prognosis. In the incipient stages it is not a question of medication. The hardening of the body against atmospheric influences by outdoor life and hydrotherapy, the increased appetite resulting from these agencies with a consequent high degree of nutritional vitality, these are the proper sources whence to look for the amelioration, if not the absolute cure, of incipient tuberculosis.

The early development of tuberculization of the lungs, long before the clinical manifestations are in evidence, is closely accompanied by two diseases, namely malaria and gastric catarrh. These conditions may be combined or independent of each other. The history of a large proportion, in fact, the majority, of cases in my service at St. Joseph's is that they have been affected with malaria and have been treated for that disease. There is a typically intermittent fever accompanying the deposition of tubercles which is apt to mislead the physician, and especially in malarial localities, the pulmonary affection may pursue its latent course unrecognized.

The same warning may be given concerning the development of gastric catarrh. The latter disease frequently declares itself in those in whom the predisposition to tuberculosis is evident, months before there appears a general invasion of the system.

Of course it may be argued that the general malnutrition arising from the non-assimilation of food so much undermines the systemic forces as to make the patient fertile soil for the development of the tubercle bacilli. But the gastric condition is found so frequently without other assignable cause as to make the careful physician suspicious of impending tuberculosis.

In this connection it might be mentioned that an elongated uvula or an acute pharyngitis may oftentimes give rise to symptoms of cough with slight hemorrhages, closely simulating phthisis. A case was recently brought to my attention by a laryngologist of this city, where in a young woman, 18 years of age, a diagnosis of tuberculosis had been made, based upon the fact that she had suffered from bronchitis, with incessant cough, and occasionally a slight hemoptysis. The cough was so persistent in character as to forbid sleep, except when a hypnotic had been given. She had grown thin and anemic, and there was so much disturbance of her nutritional centres that food could not be assimilated.

There was nothing about the lungs to indicate an impending tuberculosis, nor could anything be found in her family history upon which to base such a diagnosis. Her ticket had been purchased for Denver, and every preparation for a long sojourn had been made. It is remarkable that her throat had never been examined, and this despite the fact that the cough was incessant, in itself a suspicious occurrence and pointing to a local affection.

The uvula was found elongated and cut, the hyperaemic condition of the throat was satisfactorily treated, after which the cough and hemoptysis disappeared and the girl never went to Denver. She quickly recuperated under tonics.

These few cases might be multiplied ad infinitum. They serve to illustrate not so much the lack of knowledge upon the part of physicians, as the carelessness with which a diagnosis is made. In this particular department of medicine there lies an exhaustive field of fertile inquiry, and with the scientific appliances which the progressive physician finds at hand to enable him to properly diagnose a patient's condition, coupled with his own skill, such mistakes should not so frequently occur.

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## THE SERIOUSNESS OF GONORRHEA.

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(From notes of a lecture delivered before the Genito-Urinary Class of the New York School of Clinical Medicine.)

"Only a clap," in a deprecatory or flippant tone, is the manner in which many comment upon having been affected with gonorrhea. The efforts made by the profession everywhere to duly impress patients with the seriousness of the disease seem to have borne comparatively little fruit, as quacks and nostrums continue to flourish with mercantile advantage. The untimely graves that are filled, the wives and children ruined by the levity with which the disease is viewed, do not seem to bring it into public importance sufficient to lead to its proper serious consideration.

The purpose of this paper is to place before younger practitioners some of the more important points which demonstrate, as has been so often emphasized, that clap is a serious disease. And it lies with these younger colleagues to conspicuously bring before their patients the need of giving weight to the ailment. Older practitioners and particularly specialists in genito-urinary diseases require none of these admonitions; their practice is made up principally from or through that immense number of people who had lightly disposed of gonorrhea as "only a clap."

The disease itself in its inception must necessarily be treated by the general practitioner. If imbued with its importance and understanding the value of the irrigation treatment, as elsewhere described (1) the seriousness of the disease is mater-

1. Valentine: "The Irrigation Treatment of Clap," International Journal of Surgery, September, 1898.

ially reduced, as is its duration. Indeed, it is due appreciation of its seriousness that leads practitioners to employ irrigations in gonorrhea.

But it is not the general practitioner nor the genito-urinary specialist alone who is concerned with gonorrhea. The gonococcus, as has been proven over and over again, spares no part of the body. And, in proportion to the distance from the urethra that is the organ invaded, the more serious the disease becomes.

Let us consider, in mere outline, the localities that are infected, and consequently the specialties that are interested in gonorrhea, and it will be seen that but few are free from it.

THE BRAIN.

Gonococci have been found to cause death by their presence in the fourth ventricle. I am not aware of their being found in the meninges, but from the character of these structures there seems no reason for their escape.

THE NERVOUS SYSTEM.

One need not long be engaged in the clinical study of genito-urinary diseases before he is convinced that a large number of the patients, especially those with gonorrhea, suffer a nervous depression. These and the few who are free therefrom, manifest many reflex symptoms, often wrongly attributed to simple neurasthenia. And the longer the initial disease is allowed to continue, the longer the apparent neurasthenia persists, even after the disease that caused it has disappeared. Whether this is due to a specific toxine of the gonococcus, or whether to the concomitants of the disease, is one of the numerous questions still to be studied. At all events much could be learned, in my opinion, if the urethrae of unexplained suicides were examined for gonococci or the lesions produced by them.

THE EYE.

The fact that the conjunctiva is at least as favorable a culture medium for gonococci as is the urethra, was manifest long before Neisser discovered the microbe. In another paper (2) statistics are quoted, showing that of 100 children born with healthy eyes and who went blind afterward, 80 lost their sight through gonorrheal infection during birth. The proportion of men who lose their sight from gonorrheal pus being carried into the eye is now fortunately smaller than formerly. To-day even the youngest practitioner does not neglect to warn patients of their danger and usually sums up his directions in:

1. Do not touch anything, especially not your face or spectacles, after handling the penis, at urinating or dressing it, until you have thoroughly washed your hands.
2. Burn bits of cotton or gauze that have been used as dressings.
3. Do not use a towel for the face after it has been used for the hands.
4. Protect the bath from infection by using a condom over the dressings on the penis, during the entire bath.

With even these simple injunctions the frequency of gonorrheal ophthalmia in adults has been materially reduced.

THE HEART.

The lining of the ventricles has been found to contain gonococci, causing death from endocarditis. Many cases doubtless have gone to the grave, in which the heart was not examined for this bacterium, which might have given the solution for an otherwise unexplained demise. Very much light on this and allied subjects is justly expected from a paper soon to be presented before the New York Academy of Medicine on "Gonorrhea as a Systemic Disease," by the eminent investigator, Boleslaw, Lapowski, M. D.

THE JOINTS.

Even novices in the profession are too familiar with gonorrheal rheumatism to warrant much more than its mention. And very few specialists have tapped the joints in hydrarthroses without finding gonococci in the fluid, if the patient has gonorrhea. That he may harbor gonococci without manifestations thereof is now well known. (3) The number of

2. Valentine: "When May Gonorrheal Patients Marry?" American Medico-Surgical Bulletin, October 1, 1895.

3. Valentine: "Recurrent Gonorrhea."—Atlanta Medical and Surgical Journal, September, 1898.

joints lost in consequence of gonorrheal inflammation speaks loudly for attaching sufficient importance to the original disease, if nothing else did.

THE FEMALE GENITALS.

In a little paper presented before the American Public Health Association (4) mention was made of the statistics which show that of 100 women dead of the diseases of the womb and adnexa, 80 died in consequence of gonorrhea, of which the husbands deemed themselves cured long before. The seriousness of gonorrhea in the male is manifest in this fact alone; it emphasizes as well the absolute need of assuring oneself that the patient is cured (5) before dismissing him in fancied security. Equally, when a woman infected with only vaginal gonorrhea ceases to have any evidence of the disease that may be appreciable to her, she should not be dismissed until searching examination (6) simple enough in itself, has proven her to be really free from gonococci.

The principal direct consequences of gonorrhea to the male genito-urinary organs need but be mentioned to recall the gravity of the disease.

THE GLANS AND FORESKIN.

Balanitis and balano-posthitis are easily cured, even if gonorrheal, by cleanliness and light dusting of the glans and lining of the foreskin with nosophen. If, however, the prepuce is long and heavy, recurrence of these affections is amenable only to circumcision, or at all events to material shortening of the sheath. Unsurgical as is the latter the operator is sometimes obliged to yield to his patient's prejudice against apparent "hebraification." Without the little operation persistent cases due to very large and heavy prepuces are intractable. The operation itself, by a method more easily shown than described in detail, is done in the physician's office, under local anesthesia only, and does not keep the patient from his business longer than the time required for the procedure itself.

The prepuce is liable to phymosis and paraphymosis as an immediate result of gonorrhea, with all the dangers of the posterior contraction.

Neglected balano-posthitis may result in very heavy adhesions of the foreskin and glans, causing deformity that may make erections exquisitely painful and render coitus impossible.

THE PENIS AND URETHRA.

The meatus may become contracted from gonorrhea. Among the consequences may be that urethrospasm so graphically described by Otis over 20 years ago, leading to retention of urine, with all its dangers to life.

The penis, in consequence of clap, may become the seat of periurethral abscesses, whose destructive tunnelings may irremediably deform the organ.

The anterior urethra readily becomes the site of chronic gonorrheal inflammation, which requires more than ordinary attention to cure (7) and until cured is not unlikely to drive the patient to despair. From soft infiltration, as described by Oberlaender, to intransitable stricture lie all the gradations that affect the urethral calibre, which destroy the patient's health and menace his life.

The posterior urethra is equally liable to chronic gonorrheal inflammation, which it can carry for years without external manifestations. It may, through anterior stricture, be caused to burst, producing urinary infiltration, needing often a life-endangering operation for its immediate relief, and too often leaving a urinary fistula that renders the patient's existence unendurable.

THE TESTICLES.

The testicles and epidymes may be destroyed by gonorrheal inflammation, with consequent abscesses, hopelessly emasculating the patient early in his sexual vigor.

THE SEMINAL VESICLES.

The seminal vesicles often become the seat of gonorrheal inflammation, with not only reflex manifestations,

4. Valentine: "The Protection of the Innocent from Gonorrhea."—St. Louis Medical Fortnightly," October 15, 1896.

5. Valentine: "The Proofs of Cure in Gonorrhea," Clinical Recorder, April, 1898.

6. Valentine: "Residual Gonorrhea in Women," Journal of Surgery and Gynecology, July, 1898.

7. Valentine: "Chronic Urethritis; its Scientific Treatment," Clinical Recorder, January, 1898.

such as intense pains radiating through the perineum to the legs, but also to recurrences of gonorrheal urethritis, elsewhere touched upon.

THE PROSTATE.

Authors differ in the frequency with which gonorrhea extends to this important gland. The lowest estimate is 33 per cent. Accepting this, then, one-third of the men who have gonorrhea are in danger not only of prolonged suffering, but go about with their lives menaced by abscess of the prostate.

THE BLADDER.

One need have seen but one case of acute gonorrheal cystitis to appreciate its physical and psychical horrors. Fortunately this disease is rapidly amenable to active treatment, especially by irrigations.

URETERS AND KIDNEYS.

The ureters and kidneys are liable to gonorrheal infection directly from the bladder. When this does not bring death it produces long and intense suffering, which is slow to yield to treatment and may require removal of a kidney.

These bare outlines, I think, warrant asking my younger colleagues to attribute to gonorrhea the serious consideration it merits.

—242 West Forty-third street, New York.

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## CLINICAL RECORD OF GROUP OF SURGICAL CASES OF SPECIAL INTEREST TREATED DURING THE PAST YEAR—HOSPITAL, DISPENSARY AND PRIVATE CASES.

BY THOMAS H. MANLEY, M. D.,
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While the sciences must necessarily constitute the groundwork of progressive medicine, anatomy, physiology, chemistry, pathology and bacteriology, each occupying an important sphere, yet the new beginner, who starts out on his career with no other guide than a crammed, ill-digested knowledge of these branches is doomed to early chagrin and disappointment. He has not yet learned the practical side of medicine, and until he does he is little more than a dangerous experimenter, bound to inflict much harm before he falls into the right path.

A glaring illustration of the wide difference between theories and practice we have recently beheld in our late war with Spain.

The credulous, unsophisticated amateur would assume from the many over-colored vaporings of enthusiasts that by the the utilization of the latest acquisitions of science and art military medicine and surgery must be revolutionized and rewritten, our advances and improvement having been so great. But what are the facts?

Well, let us candidly confess the truth and admit that though 33 years have passed since the Civil war we have no evidence that in those three decades any great advances have been made in medical or surgical prophylaxis of campaign life. Antiseptics have sustained a bad setback, the mortality from abdominal section has been great, while those penetrating wounds of the peritoneum treated by the let-alone plan have generally done well.

Dr. Senn's late contribution from the Relief points to practically nothing new, and again comes the worst blow to sanitary science, our boasted mastery over the contagium is little more than a myth. Our panic-stricken commanders at the front pitifully appeals to the Government to transport their army North before the pestiferous diseases of Cuba blot them out, as neither hygiene nor medical art is competent to prevent or mitigate them. This short war has taught us, as the Madagascar campaign did the Italians, a practical lesson, and led us to question many things which our laboratory authorities would have had us believe were as fixed and immovable as the fabled laws of the Medes and Persians.

The practical, or the clinical side of the healing art is its very soul and life. Let the novice witness the treatment of a half dozen fracture

cases, and it will do him more good than a month's reading on theory and speculation. It is therefore of vital importance that our collateral studies of the cognate branches of medicine be illumined, leavened and strengthened by clinical studies and immediate personal observation.

The record of cases by an unbiased observer is always of interest and value; therefore in this instance, with the very limited space at my command there will be noted a few cases of a class of lesions of more than passing interest.

FIRST: TUMORS OF THE LYMPHOID ABSORBENTS.

Briefly and roughly speaking, though tending to suppuration or extensive and rapid hypertrophy, these tumors are either specific in the inguinal region, and tuberculous in the cervical.

Thirty-four such cases have come under my care in the past year, most of them having been sent to me for surgical treatment. This meant that palliative measures had entirely failed.

My course in these cases is incision and ablation complete.

In all these cases a free, wide incision provides us with great security in dissection, but in the submaxillary, or supra-clavicular areas of the female, for cosmetic reasons we are often forced to make as small an incision as possible, with a view of leaving a minimum cicatrix.

Strumous neoplasms in the internal cervical areas are removed with ease and rapidity in most instances by an experienced operator. If the inexperienced undertake these operations on the neck he should first make a few thorough dissections on the cadaver; else serious consequences through damage of some of the many vital structures which pass down over the cervical isthmus is possible. After complete enucleation here we should close with fine silk rather than gut, which leaves a rosary of scars.

The excision of bubonocele is not difficult, because we may here widely expose the deep parts by a free incision; caution only is required that in dissecting we nibble carefully with the blade when we sink down on the great blood trunk, and always keep close to the capsule. It is curious to note that in venereal bubo,do what we will, primary union of the incision seldom occurs. It has been said that this is because the integument cannot be well disinfected here. This is an error evidently, for the reason when we cut in this situation over the inguinal fold for hernia, spermatocele or other condition, the parts promptly close in.

SECOND: FRACTURES.

During the past 12 months 53 cases of fracture have come under my care and notice.

It is a most singular thing, but the fact remains that of late years there has been neither in England nor America a real, up-to-date work on the management of complex fractures. Here the young man is quite at sea, for one author will tell him that immobilization is necessary from 1 to 3 months. He tries it on a fat old woman with an intracapsular fracture of the femur, and he is rewarded with a vast bed sore, and later, possibly, death. He next tries it on a colles. After a month, when the fixation is removed, he finds every joint carpal and digital anchylosed. Turn again to a French surgeon's late work on fracture treatment and we will find that he urges the ambulent treatment with no splints at all, and motion with massage from the very first day.

The fact is that the proper treatment of fractures in general is a science in itself, of which the profession as a whole know very little. But few are familiar with Ollier's monumental work on this topic, or the fact that a fracture, like a lesion through the soft parts under proper treatment may often do solidly unite by primary union. My course in fracture treatment is based on simple fundamental principles, the most cardinal being not to in any manner embarrass the circulation.

Our greatest and most substantial advances in this direction have been through utilizing osteoplasty in compound fracture, and the application of prothetic apparatuses. An enormous gain, too, has been possible by embalming all serious shattered fractures until the demarkating line is formed, if it form at all; in other words, dispensing in toto with pri-

mary amputations. It has been my invariable custom in all fractures, simple and compound, not to apply any permanent adjustment until all inflammatory reaction has subsided.

The Roentgen rays have been an aid in some cases, but there are many non-displaced fractures about the joints where its revelations are most delusive or negative. As a diagnostic aid in fractures its value has been rather overestimated.

One of the most serious cases of fracture of a large bone shaft that has come under my charge this year was sent to me by my friend, Dr. R. H. Cowan, the chief surgeon of the Norfolk & Western Railroad. The young man 13 months before had sustained an extensive compound comminuted fracture of the right femur, with several other serous injuries of the body.

He finally made a good recovery, but at the side of fracture there remained a cushion joint, with a sharp, angular deformity, rendering the limb both painful and useless for support.

It was simply a question between amputation and restoration of position and function by some osteo plastic operation.

He was a young man with a fine constitution, and hence there was no doubt about the presence of ample regenerative action in the tissues. But, the femur is the one bone shaft which is exceedingly intolerant to mechanical manipulation, after a recent fracture, although for pathologic states we may accomplish much through surgery. Briefly, it may be said that an operation was performed, an exceedingly difficult and bloody one, by which all the diseased bone was removed and the ends of the fragments solidly wired. The case has followed an uneventful course, promising to yield the happiest results as to position, strength and function.

### THIRD: HYDROCELE, VARIX, NEOPLASM, INGUINAL VARIX, SERIOUS CYSTS, HERNIO-SEROUS CYSTS OF THE SCROTUM.

Thirty-seven cases of the above class are recorded in the annual of the West Side German Dispensary, and in my service during the same period as preceding cases; with what have been seen in my private practice and consultation in the same time, would nearly double the number.

To classify and arrange this group on an anatomical or pathological basis in the present instance, important and valuable as it would be, is impossible. Attention is particularly called to them here, because of their comparative frequency, the difficulty in their diagnosis often, and the value of an aseptic incision under many circumstances, both to clarify diagnosis and simultaneously as a therapeutic resort institute surgical treatment. In four old chronic cases, hernia, hydrocele and varix coexisted. My rule of practice has been with this class to advise and practice radical surgery in the young of vigorous health, but to discourage operating in the feeble or aged, unless threatening symptoms are manifest.

In infants and youths, when diagnosis is at all doubtful, a free incision is invariably practiced.

When this is done aseptically and the patient keeps the bed for a week or two recovery promptly follows, with few exceptions.

Note.—This remarkable and unique case will be reported in detail after cure is complete.

### VAST HERNIO-CYSTIC TUMOR OF SCROTUM.

Among this group was one remarkable case of right inguinal hernia, with a vast multilocular cyst of the scrotum. The entire mass was supported by braces crossing both shoulders and reaching down below the knees. I had it weighed in an empty starch box turned on its end. Weight, 16 pounds and seven ounces. Diameters over its antero posterior or long axis, 27 inches; circumference, 26 inches. Contained a fluid of oily consistence and coffee color. This mass was treated by free evacuation, more than a gallon of fluid having been evacuated. On operation it was found to consist of the separate dermoid cysts, one having a thick, cartilaginous investment; both contained an abundance of putty-like mass and gave issue nearly two gallons of chocolate-colored fluid.

After operation the hernia was readily reduced.

FOURTH: HEMORRHOIDS, ITCH, ULCER, PROLAPSE OR STRICTURE OF THE ANO-RECTAL OUTLET—CASES.

In period stated 37 cases of rectal affections have come under my notice and treatment.

The most common and troublesome affections of the rectal outlet is piles, and, as there are multiple varieties of them, it goes without saying that treatment must be modified in various circumstances, though one common rule should be observed under all circumstances, viz., not to needlessly multilate or cut when tentative measures may succeed.

It has therefore been my custom in practically all but ulcerating piles to be content with cocaine analgesia, dilatation and pressure massage. No scalpel or instrument can reach the source of hemorrhoidal disease in the portal system, or the vasomotor plexus.

My procedure, when feasible, dispenses with the dangers of pulmonary anesthetics, large hemorrhage or infection after operation; besides its effects are most gratifying and effective.

Rectal ulcer is frequently the cause of anal pruritus. Ulcers dependent on tubercle syphilis or cancer precede stricture. When stricture sets in hemorrhage and fecal leakage quite generally attend it. In women we must be cautious not to confound a retroverted fundus uteri on the rectum for a new growth. Prolapse of the anus in the young is usually self-curable, but one case of a most aggravated description came under my care in the early spring, associated with extroversion of the bladder, the patient being but four months old.

In middle life and later no rectal lesion will call for greater tact, skill and judgment in its treatment.

This condition possesses quite all the etiological features of a hernia, and hence similar principles apply to the treatment of both.

In five cases seen by me among the enumerated group three were in females. In this sex we find it the most common and quite invariably associated with a collapse of the bladder, vagina or uterus.

COLO-RECTAL INERTIA.

I can find no mention of this pathological condition in the literature of medicine. Much will be found on constipation, but this is something more. The colon and rectum are jammed, packed full, with a superadded diarrhea and fecal leakage.

During the past winter after an operation on a gentleman for phagadenic appendicitis he complained to me of a "drip" coming away from his bowels, which had annoyed him for some weeks before the operation.

On examination the rectum was found packed with hard fecal masses. The anal sphincter had to be widely dilated and large irrigations employed before it was possible to dislodge the enormous accumulation. Under similar circumstances of general enfeeblement of the body, and when the patient complains of a "soiling of the clothes," it is always well to explore and empty the rectum at once.

In the case cited, immediately on mechanical evacuations, pain, distension and languor quickly disappeared, appetite, sleep and strength were restored.

SIXTH: CASES OF THAUMATIC AND PATHOLOGICAL CONDITIONS OF THE EXTREMITIES.

A brief notice only here can be given to certain inflammatory conditions of the joints, traumatic or pathological.

More than one hundred cases of this class have been handled at my clinic in dispensary, in hospital and private practice within one year. A little more than a third were traumatic, about a quarter either tubercular or syphilitic; there were seven gonorrheal, the remainder were of a neuralgic or rheumatic character.

The unsatisfactory results in the treatment of this class of cases often arises from two causes. The first is an imperfect knowledge of the anatomy of the extremities, and the next is through a hasty or imperfect investigation into the causation. For example, how often one is treated for synovitis when the effusion is inflammatory and entirely external to the joint in a neighboring bursa? And how often may a gonorrheal or tubercular arthritis be confounded with rheumatism. Again, it is now well known that articular degeneration may have its source in the spinal centres.

Late years have witnessed a marked back-setting in those extensive

dissections of joints so recently practised on the articulations.

Arthrotomy in my practice has been proved to be very rarely required. Young children outgrow many joint lesions. In adults tubercular arthritis very often co-exists with pulmonary implication.

A large proportion of the cases coming under my care were entered for the relief of pain and stiffness in the joint. In many the dominant surface features pointed to rheumatism, though the history indicated trauma. This is an important point to note, for my experience has forced me to believe that in many of a gouty or rheumatic diathesis a trivial injury of an articulation may stir into activity a rheumatic, chronic inflammation. It therefore follows that in many of these, constitutional treatment must go hand in hand with local measures.

For local treatment, in the majority of cases of joint pain nothing is so prompt and decisive in its effect, as acupuncture, followed by accelerating the joint action and bandage support. As a liniment nothing excels for these cases the following, first employed in this country by myself. It sometimes seems to almost work wonders:

R—Acidi salicylici .....dr. iv ss
Tr. opii.....dr. iii
Spts. vini rect. dil.....oz. ii
Ol terebinthin .....oz. i
Ol. dulcis, qs. ad.....oz. viii
M. Sig.—Liniment.

We must eliminate the opium tincture in growing children. It may be applied by inunction or by saturated flannels. The hand must be well oiled, which is to rub it in.

SEVENTH: HERNIAL CASES.

Fifty-seven cases of various types of hernia came under my care in period stated.

Thirty were in infants and children, 12 in middle-aged and young adults, and 15 in old people. It is curious to note how common this infirmity is in men over 60, especially with those who suffer from prostatic or vesical disease, and it seems remarkable, too, that their ruptures tend to take on the infantile type, i. e., they are prone to cystic complications.

Surgery can do much for various types of hernia, though it cannot cure or relieve all.

My rule has been, to recommend the truss when it can be worn with comfort, when the rupture shows no signs of complications, is not augmenting in volume nor threatening strangulation. This rule is deviated from, however, with young women, in whom kelotomies are generally followed by the most gratifying results, and besides in those with whom the males blemish may constitute an impediment in physical examinations. As operations, secundem artem for non-strangulated hernia is quite devoid of danger we rarely decline to perform them on healthy subjects in early life.

EIGHTH: POST PARTURIENT EVENTRATION.

Two cases of remarkable collapse forward of the abdominal walls after labor came under my care recently, both seeking relief from the so-called "pot belly" by surgery. Both were young women, who had gone through normal labors, but below the umbilicus it was quite evident that over the anterior lateral aspects of the abdomen no vestige of muscular tissue remained. The floating viscera tumbled in a thin, attenuated pouch over the pelvic brim, and with the hand one could readily pick up the parchment-like envelope and readily feel the vermicular movement of the intestine.

Both women were in good health and showed no signs of disease of any of the pelvic organs.

I had once seen, post-mortem, a similar condition in a woman who had for 30 years a large uterine fibroid.

After a careful study of these cases I could not see my way clear to conscientiously recommend any description of surgical operation, although before they came to me both had been assured that they could be "cured by a very simple operation."

NINTH: SURGERY OF THE CAVITIES—CASES.

Surgery of the cavities has been vastly overdone, or rather, indiscriminately employed. One case that I trephined for epilepsy relapsed at an early date. The scalpel can do little for pulmonary lesions except in suppurative conditions; but every year we are steadily enlarging the field of abdominal and pelvic surgery. Four cases of large fibroid, 15 of salpingitis and eight of

uterine cancer are enumerated in my annual collection. There were nine cases of pyelonephrosis, calculous and tuberculous; 27 cases of appendicitis, one of renal carcoma, six of pyloric obstruction, all malignant; one of cancerous stenosis of the esophagus, and one of ileus.

No branch of surgery offers better and more satisfactory results in properly selected cases, and when dealt with by skilled, experienced hands, than that applied to the abdomen and pelvis; while, on the contrary, indiscriminate, rash or unskillful operating here is murderous. The master of this work must know practical anatomy well, have done plenty of vivisection and have had clinical experience. It has been my experience that when we operate here in the absence of acute inflammation, results are very generally satisfactory.

Experience has taught me, too, that safe and rapid operating is greatly enhanced by a free incision, which when properly closed in no wise favors hernia any more than a small one.

From what I saw last year in the English and French hospitals I have been led to largely discard drainage in all abdominal cases unless when dealing with a suppurative condition, or secondary hemorrhage is feared.

TENTH: TUMORS OF THE MAMMARY GLAND.

Since October 1, 1897, sixteen of these cases have come under my notice or care, four in consultation. Of this number four were of a benign character.

Although the general rule now is to clear away the whole chest wall in the ablation of cancerous breasts still my own views on this lesion and the results which I have seen after those large dissections have not inclined me not to adopt it. I have been led to the more restricted operation because no single case of clearly established cancer in any situation has ever been seen by me cured by any operation, and further, when the axillary hollow and the supra-clavicular spaces are entirely cleared of obstruction the venous and lymph currents is certain to follow, with more or less neuralgia in the upper extremity, edema and marked elephantiasis. Operation for true cancer, then, should always be regarded as little more than a palliative resort.

Two of the cases in this number had been pronounced cancer, one of which was a dermoid cyst and the other a deep-seated tubercular abscess. No doubt, however early, extirpation offers the greatest security against early return, and should be particularly recommended in young people; but with decrepit, old women mammary cancer is generally quite painless and pursues a very chronic course, hence in them sanguinous measures should not be urged.

ELEVENTH: STRICTURES IN THE CERVICAL SEGMENTS OF THE ESOPHAGUS.

Stricture of the esophagus is very often one of the first symptoms of cancer in the posterior anediastinum, though we will rarely meet with it until after middle life.

My patient was a young lady who came to me in May. Ten years previously I had removed her right hip joint for tubercular disease.

But now she was hale and hearty and was enjoying good health until about ten months before she reported, when she had difficulty in swallowing, beginning by requiring a special effort to swallow solids. Later this became more pronounced, when no solid food whatever could be forced down without a prompt regurgitation. For more than a month she subsisted entirely on liquids.

It was at first thought that the trouble was neurotic, but antispasmodic remedies produced no influence, and besides the clinical history was against it. She now had a large tuberculous ulcer of the leg. She was 22 years old and unmarried. Could she have had a tuberculous ulcer of the esophagus, which on healing left a contracted state of the lumen, or might it not possibly have been syphilitic? I can find no case on record of tubercular stenosis of the esophagus, and her life has been such as would lead me to reject venereal, absolutely.

The surface examination of the neck revealed nothing. On passing in a small bougie, an obstruction was encountered on a level with the sixth cervical vertebra. It would not permit a larger one to pass. I then took

the smallest size and easily passed it on towards the stomach. This was repeated when larger and larger sizes were passed, until one, the full diameter of the esophagus went through. The results were most gratifying, and now she has no trouble in deglutition, swallowing with ease any description of food coming before her.

TWELFTH: TRAUMATISMS INVOLVING THE MUTILATION OF THE JOINTS AND SOFT PARTS—CASES.

A large number of injuries involving fleshy parts have been seen during the past year, most of them being lacerated or fractured, and attended by contusions.

It strikes one as rather remarkable that young practitioners will persist in sewing up lacerated wounds. Imbued with a profound conviction that provided only a wound is amply scrubbed and pickled in an antiseptic solution, immutable and fundamental laws of surgery may be ignored with impunity.

An example of this came under my notice very recently.

A high official of this city, rusticating with his family in the Catskill Mountains, one morning mounted his horse for a ride. The animal shied at an object and became unmanageable, when the rider was thrown off, sustaining a deep, lacerated wound over the metocarpo-phalangeal joint of the little and ring fingers, right hand. The gash bled very freely. He was promptly attended by a physician, who immediately sealed the opening with deep suture. Three days later, as serious symptoms were developing, he was brought home. The following day I was invited by his New York physician to see the wound. Things now were indeed in a menacing state. His hand was bloated up, the sutures had ulcerated out, a purulent tendo-vaginitis had extended into the deeper part of the hand and the first phalanx of the little finger was bare on its inner aspect. Along with this he had a temperature of 104, with recurring rigors and bodily weakness. Incisions, counter incisions, irrigation and drainage were employed, while he was plied freely internally with whiskey and quinine. He had a narrow escape from losing the hand, but the little finger had to be amputated.

In some of these cases of lacerations of the hand, in the summer season, unless prompt and efficient remedies are supplied gangrene may set in with destructive energy and destroy I saw with appalling rapidity.

Some years ago after a deep laceration of the palm by a butcher's hook, in which the wound was sewed up within 36 hours, mortification had set in so rapidly and extensively that I had to amputate at the humerus scapular articulation at the shoulder to save life.

The most valuable of all remedies for all deep lacerations are cold alcoholic solutions, but always leave the wound widely open.

Another mistake in treating lesions which open into the joints or involve a fracture of bone is the employment of strong antiseptic solutions, which by their irritating properties often start up a low grade of endosteal or perichrondrial inflammation, difficult to subdue without resort to resection or amputation.

RESUME AND SPECULATIONS.

Let no one delude himself into supposing that any advances, no matter how great, during the past 25 or 30 years have in any manner revolutionized the fundamental principles of surgery.

A greater latitude of action is now possible, through anesthetics, by which our patient is rendered temporarily dead to all sensations, and our work is not entirely unlike an autopsy. This permits leisure, accuracy and precision, without which progressive operative surgery would be impossible.

Lister taught the world the doctrine of cleanliness; the inventions, industries and discoveries of modern times have contributed vastly to progressive and special surgery, and as above than all, the masses have torn loose from the chains of the despot, the democratic spirit has taken deep root, and poor, struggling humanity is now permitted to enjoy some of the fruits of toil and labor; everyone is better fed, domiciled and clothed, and the accursed "famine fever" of former times is no longer possible. Therefore why the patient stands the shock of operation with comparative immunity and the

death rate has been enormously lessened.

PROPORTION OF SURGEONS TO THE WHOLE NUMBER OF PRACTITIONERS.

The number of surgeons, general and special, has enormously enlarged during the past 20 years; but it must enlarge more yet to meet the demands of the times. In fact, except for infectious diseases, there is now little call for the physician. Medical nihilism is rampant, and surgery has come in to swallow up all the plums in practice.

With this keen competition the one maintaining himself by surgery exclusively must needs exercise a ceaseless vigilance, combined with continued autopsy work, vivisection and a practical knowledge of his art through incessant application and observing not only the methods of different operators and their brilliancy in execution, but their faulty judgment, their errors and mistakes.

SIMPLICITY IN TECHNIQUE.

Although there are not a few, excellent surgeons who leave nothing undone for dramatic effect in playing to the house, the keen critic, and even the intelligent layman soon sees through it, and it rather serves in the end as a boomerang.

What we need is not a great array of instruments and a large retinue of begowned assistants, but a few thoroughly good and reliable ones.

PAIN AND SHOCK.

The immediate mortality from operative surgery comes from pain hemorrhage shock. Pain is a monitor which much be heeded and not stifled by narcotics, until its cause is clearly unmasked. Operative pain is no more, since we have anesthetics and analgesics. But it is better not to risk anesthetics unless an operation is to be protracted, or very painful.

In all surface or peripheral operations now we have in cocaine one of the greatest boons ever conferred on humanity. Let the practitioner master well its technique in surgery. Hemorrhage is what always tries the mettle of the operator. Very many sink after operation from great loss of blood. Blood is our very life itself. Economy of it in surgery contributes more towards salutary results than any other single factor in operative surgery.

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## UNGUENTINE.

BY JOSEPH R. CLAUSEN, A. M., M. D.

Repeatedly of late has our attention been called to the remarkable results following the use of the new surgical dressing manufactured by the Norwich Pharmacal Company, and called by them Unguentine. Our attention was first directed to it by a very able article by Dr. Edward B. Jackson, of Houston, Tex., which was published in the Texas Medical News under the caption of "Wet Dressings Versus Dry Dressings," in which, after enumerating the drawbacks to the use of ointments as dressings, the doctor says:

"It is almost needless to state that an ointment must in its own corporate body be strictly antiseptic, and with this end in view it should be composed of a petrolatum base, since everyone is only too well aware of the early tendency of fatty vehicles to become rancid, and therefore within themselves septic, in which event their action, when not positively dangerous, is plainly nugatory. Asepticism in an ointment is not less demanded than in a liquid portion for purposes of ablution or ingestion.

"There has been great disappointment in obtaining this stable condition in the zinc, mercury and other preparations, heretofore proposed, short of a strength violently irritating to the structure, and the profession, weary of witnessing the absence of antiseptic properties in zinc and other ointments, are almost unanimously abandoning their use. To meet the requirements heretofore enumerated an ointment should contain a reliable antiseptic, a moderate styptic and astringent—say one part of Lord Lister's sheet anchor, carbolic acid, to 50; one part of ichthyol to 20; one part of alum to six of the base—(petrolatum).

"The Norwich Pharmacal Company's formula of unguentine con-

tains carbolic acid, 2 per cent.; ichthyol, 5 per cent.; alum, 15 to 16 per cent. 'By a process of their own they eliminate most of the astringent properties of alum, thus rendering it non-irritating in this large amount. The base of unguentine is pure petrolatum.' There is probably no known drug of greater utility in the treatment of putrescent open sores than alum. This has been the common intelligence of well-informed physicians for ages. What heretofore restricted its wide range of usefulness—its irritative properties—has now been removed by the chemists, and we have in the preparation—unguentine—the best surgical dressing ever yet offered the profession."

Once interested in the matter we have followed it up first, by careful inquiry, and later by experiments in our own private practice. The results in each case lead us to say that unguentine has the largest field of usefulness of any surgical dressing we know of, and for this reason is destined to be used more extensively by the profession throughout the country than any other similar preparation. Surgeons, obstetricians, gynecologists, dermatologists, rhinologists, otologists and general practitioners will alike find it valuable, after once becoming acquainted with its virtues.

For quick results we have found nothing to equal it in the treatment of burns, scalds, abrasions, excoriated surfaces, suppurative tumors, ulcers, bed sores, inflammatory, cutaneous diseases, piles and as a dressing after operation and in minor surgery.

Did space permit we could cite cases under our own observation in which it has demonstrated its curative qualities in each of the ailments above referred to. One of its most recent successes we will alone refer to. A prominent divine of this city, pastor of one of its leading churches, had for years suffered with an aggravated form of piles. Almost every remedy at the command of the general practitioner had been brought into service to allay the trouble, but temporary relief at times was the only result. Three applications of Unguentine were sufficient to bring relief such as he had never before experienced, and after two weeks' use of the curative all indications of inflammation entirely disappeared. This same rapidity of action has been a noticeable feature in every case where we have deemed its use advisable.

Now a word about the characteristics of the formula of Unguentine. And first, Unguentine is peculiar. When it is applied to a wound or other lesion it forms at once a thin film, totally excluding the atmosphere, thus preventing bacterial invasion. No other surgical dressing does this. It is thoroughly antiseptic, non-irritating, astringent, yet soothing, quickly relieving pain whenever there is inflammation. It is the modification or the Americanization of the old Sir Astley Cooper's alum ointment by the addition of carbolic acid and ichthyol, with a petrolatum base. The formula, which should commend itself to every intelligent physician, is as follows: Carbolic acid, 2 per cent.; ichthyol, 5 per cent.; alum, 15 to 16 per cent. By a special process most of the astringent properties of the alum are eliminated, thus rendering it non-irritating. The ointment base is the purest of the petrolatum products of the Baker oil fields, and is absolutely without taste or odor, free from the acidity which so often contaminates the cruder petrolatum products, and cannot become rancid. Thus two demands of the perfect ointment have been met. The well-known properties of the alum salt have long been known, but its use has been limited because of its irritating qualities. This objectionable feature has been eliminated by the special treatment referred to, while the soothing and healing properties of the drug are fully sustained. Ichthyol and carbolic acid are too well known as cicitrizants and antiseptics to require further mention, but it would seem as though these qualities had been reinforced by their union in Unguentine.

The late Dr. William Pepper, of this city, has said that "medicine and surgery have made more progress in the last 20 years than in the 20 centuries preceding." The same thing can be said of surgical dressings, and Unguentine is an evidence of the fact.

# Editorial

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## THE NEW YORK SCHOOL OF CLINICAL MEDICINE.

Our readers are treated to an unusual amount of valuable original material with this number from the members of the staff of the New York School of Clinical Medicine. This school is composed of instructors of world-wide reputation for ability in professional matters, and it is with no little degree of satisfaction that we present to our subscribers a number of this journal containing articles from men of such high reputation in their respective specialties. The school itself, though young among institutions, is well equipped in material calculated to be of vast advantage to physicians requiring post-graduate courses. It is well situated, has abundant clinical material and possesses strong instructors.

Our position has always been and is to-day that every hospital, dispensary and teaching institution should be open gratis to any graduate in medicine who wishes to improve his general knowledge.

But specialties have come and the general practitioner must go. Go where? Where he can steal their thunder, where he can fit himself for a specialty.

As things are to-day, it is imperative for every practitioner to cultivate some special branch along with his general work, and here come in the need for special training and instruction. Modern advances have made it imperative on practitioners to, after 10 or 15 years, turn out, as it were, a "new edition of themselves."

As for the methods of post-graduate instruction, those of the New York School of Clinical Medicine are particularly to be commended, as here the teaching is entirely personal; there are no long-worded dissertations on speculation and theory, and the matriculent is permitted and required to himself examine and report on the cases coming before him for opinion or treatment.

This school knows no creed, code or color, only requiring that the matriculant be a graduate in medicine, and is earnest in his desire to acquire knowledge.

The terms are moderate and we understand special rates may be made to those who take all the branches, or take out an annual ticket.

## BLOODLESS OPERATIONS FOR HEMORRHOIDS.

Nine years ago the writer described and published "The Bloodless Operation for Hemorrhoids." This was recommended after witnessing a similar procedure in the Parisian hospitals, and after he had treated more than 25 cases of piles by the method submitted in his own practice. With it pulmonary anesthetics will seldom, if ever, be necessary. The anus is cleaned, thoroughly dilated and everted, the parts anesthetized by cocaine, on the periphery and subcutaneously, when the hemorrhoids are each seized, stretched, twisted and crushed between thumb and fingers. This having been thoroughly executed without the slightest suffering the parts are washed and returned, to undergo a painless atrophy and resorption.

Dr. Louis Strauss, of St. Louis, and others have denied that this procedure is based on scientific principles and can carry no weight except with the laity.

But it will effect rapid and permanent cures, without imperiling the life of the patient. No blood is lost, no retention follows with stricture or fistula. The dangers of an anesthetic are obviated, and in simple cases without internal complications the patient may go on about his usual occupation immediately after treatment.

It is only necessary to remember that hemorrhoids are not a disease ani-generis, but the manifestations of a disordered condition in the chylopoietic viscera, the liver and portal system, and that the state of varix or hematocele is often hereditary. Hence, along with local treatment, such diet must be given and such medicines administered as are known to correct the pathologic state.

It is therefore our duty as far as possible to obviate the necessity of any mutilating procedure on the rectum for hemorrhoids, which is attended with danger; and that this danger is not of a visionary, alarmist character may be gathered from the salutary warning of the most distinguished rectal specialist in America, as is here noted.

### DANGERS OF RECTAL OPERATIONS.

Joseph M. Mathews (Philadelphia Medical Journal) mentions three sources of danger in the operation for internal hemorrhoids. These are hemorrhage, sepsis and contraction of the anal orifice. To obviate the last the author recommends the introduction of the finger, well anointed, into the anus. Especially should this be done after the ligatures have separated. When contraction does occur it should be broken down with a speculum or dilator.

For operations for fistula in ano the danger is injury to adjacent structures or organs, but the main one is division of the sphincter muscle, which refuses to be repaired. So far as the author's reputation is concerned he would much rather do a half-way operation for fistula in ano and fail to cure his patient than so to divide the sphincter muscle that it could not be repaired. In operations for rectal polypi the author advises against the use of instruments, as they are easily torn off. Should hemorrhage occur, the author uses a plug of iodoform gauze around a hard rubber tube, inserted as high as it will go after dilation of the rectum with a dilator or speculum. If a violent hemorrhage is anticipated he soaks the plug in a solution of iron persulphate, diluted half and half with water to avoid the danger of sloughing of the mucous membrane.

The internal hemorhoids known as capillary piles are dangerous, because they bleed vigorously. The author emphasizes the fact that violent hemorrhages from the rectum, without any previous history of disease will generally be found to have their origin from a point about an inch within the rectum. In these cases, after first giving an aperient and washing out the bowel thoroughly, he opens the rectum with a three-valve speculum or dilator. He then takes a piece of iodoform gauze and dips it in a 5 per cent. Monsel solution. It is made cone or bag shaped and deposited just inside of the rectum. A hypodermic of morphine is then given. The plug is retained as long as possible—for two or three hours.

## TYPHOID PNEUMONIA.

At the recent meeting of the American Medical Association H. E. Tuley (Louisville) related a case in which many of the symptoms pointed to typhoid fever, yet no evidence of this disease was found after death except slight enlargement of the mesenteric glands. On the twelfth day signs of consolidation of the lungs appeared, and the necropsy showed the lungs to be almost completely consolidated. Bacteriological examination of the lungs revealed only the diplococcus pneumoniae. In such a case, Tuley thought, the term "typhoid pneumonia" seemed justifiable.

Typhoid pneumonia is a term which has been current, if not in the medical literature of the day, at least in the descriptive phraseology of numerous practitioners when describing a class of cases with intense virulence of the systemic symptoms, the latter frequently being accompanied with but slight pulmonary involvement.

It is found in the young and the aged, and in the weak as well as the robust, and while the distinctive symptomatology characterizing the development of a true typhoid is not found there are often present the epistaxis, the intense cephalgia, the tympanitic distention of the abdomen, the sordes, the dry, brown tongue, and frequently diarrhea.

These symptoms are especially indicative of a low state of the systemic forces, or the addition of some other bacillary influence supplementing by its presence the toxic influences of the diplococcus pneumoniae.

There can be no question that what we term pneumonia is frequently a systemic disease in the beginning, which during its development localizes itself in the pulmonary tissues, and while the addition of the word "typhoid" to the pneumonia is objectionable—as all hybrid terms are to be condemned—there is no phrase more descriptive of this combination of symptoms. J. J. M.

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## HUNGER AS A THERAPEUTIC MEASURE.

Two very interesting articles on "Hunger" have been published in a current issue of a leading monthly magazine, one being from the pen of Mark Twain, the other from the well-known editor of the Popular Science Monthly, Dr. Youmanns. The brilliant writer of the "Innocents Abroad" in a semi-satirical vein relates his experiences at several of the well-known foreign spas, and though the article was written more to amuse than instruct, yet there are many valuable truths embodied in the vein of fiction which runs through the story.

From a scientific standpoint does the brilliant editor of the Popular Science Monthly deal with his subject, and in a very readable way he discusses "Hunger," reciting the influences that various drugs, such as cannabis indica, opium and other narcotics have upon the various ramifications of the great sympathetic system.

The moral of both articles, briefly stated, is that we eat to much, and at times when there is no disposition upon the part of the alimentary organs to digest food. It is much better, instead of eating food at stated periods to wait until the craving of the stomach demands food, no matter how long that may be, presupposing, of course, that the digestive organs are in a physiological condition. From a disease standpoint the stomach may be in such a low, nervous condition that the lack of nutritional tone may be intensified to such a degree as to make no demands for food.

There is much to be said in favor

of the facts contained in both articles, for it cannot be questioned that we eat entirely too much for the proper preservation of the natural forces of our systems. We are constantly accumulating more than we make use of, and despite the fact that we have a surplus of tissue, we are in a state of physiological bankruptcy.

On the other hand it must not be assumed that starvation is a therapeutical measure to be generally advocated. It is commonly known that starved animals are more liable to parasitical affections, and to contagious diseases.

The water-starvation cure, which some years ago was very extensively tried in Germany under the name of "Schroitis' cure," undoubtedly did much good in a selected number of cases, but the danger to be feared from such inventions is that people are apt to believe them to be of universal application in numerous diseases, where they accomplish more harm than good. People taking the above "cure" were kept for four days on two small glasses of hot wine per diem; then allowed to drink freely for a day; in the meantime hot wet packs were utilized. The fluids of the body by this process were diminished, the blood made more concentrated, and in certain diseases where dropsy was a marked symptom much good was realized.

The general conclusions to be derived from both articles are that Americans as a rule consume an excessive amount of food, the excesses being most pronounced in the line of meats and sweetmeats.

J. J. M.

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## NEWS ITEMS.

Dr. Paul Gibier, late of the New York Pasteur Institute, is building a new sanitorium in the Ramapo Mountains, and has appropriately named the village Pasteur in honor of the great scientist. We are promised detailed information from the pen of Dr. Gibier in some future issue, but have learned from him that the buildings are surrounded by sunshine, so that a valuable "sun bath" can be given, and the climate and hygienic and dietetic therapy shall constitute the stronghold of the treatment.

Protected as this place is by the surrounding mountains from the north winds it will be well adapted towards favoring convalescence in tuberculosis.

Dr. Louis Fischer has been elected secretary of the New York School of Clinical Medicine.

Dr. John J. Morrissey has been elected Professor Practice of Medicine.

Dr. Herman Collyer has been elected Professor of Gynecology.

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## NOTICE.

Several papers from the members of the staff of the New York School of Clinical Medicine, which arrived to late for this issue, will appear in our next.—Ed.

# Clinical Medicine.

In charge of DR. J. J. MORRISSEY.

REST: A NEGLECTED FACTOR IN GASTRO-ENTERIC DISEASES.

In a paper on this subject at the recent meeting of the American Medical Association C. V. Spivak (Denver) protested against the too frequent and general use of lavage, galvanization and other local mechanical measures in the treatment of gastro-intestinal diseases. His own method was to advise rest in bed in all serious cases, with entire abstinence from food for at least from one to three days, nutritive enemata being used if longer abstinence was necessary, with poultices over the epigastrium, which gave comfort and acted as a splint for the stomach. He recited histories of cases with hyperchlorhydria, gastric disturbance with pulmonary tuberculosis, membranous enteritis and other affections in which failure of permanent relief by the usual methods of treatment was followed by an entire cure of permanent amelioration of symptoms when the rest cure was employed. He considered this treatment indicated in all neurotic cases, in all cases with pain or diarrhea, and in almost all tuberculous cases, and he thought it never contraindicated.

The above is certainly a radical departure from the scientific method of treating diseases of the stomach so earnestly advocated by men whose special lines of study lead them in the direction of ailments of that organ. And yet it may be strongly questioned whether the scientific method is based upon the principles of common sense. To introduce a tube into a patient's stomach in order to show the facility with which it may be done, or to demonstrate the latest mode of treatment rather than use the time-honored routine of diet with suitable restrictions for each individual case may be scientific, but it is not sensible.

The entire absence from food from one to three days, nutritive enemata being in the meantime used, appeals strongly to our sense of what is due to the patient, and appropriate as to treatment.

There are many appliances used in surgery; there are modes of treatment advocated in overcoming disease in the present day, simply because they are supposed to represent the latest discoveries in both departments of medical science, but it is a question as to whether the patient is or is not benefited. The circulation of such ideas as those given in Spivak's paper will do much to recall us to the common sense principles which should underlie not only affections of the stomach, but all disease.

J. J. M.

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In the Lancet of July 23 a paper is presented giving a summary of cases treated by tuberculin R. The point of particular interest to which we would draw the attention of the reader is this declaration on the part of the authors: From a very careful observation of the effects of tuberculin R. given alone in doses as prescribed by Koch, and not accompanied by any other treatment on cases of phthisis pulmonalis we are able to announce four cases of complete recovery out of 13 cases treated. These four cases were the most favorable for treatment, as the disease was localized and the temperatures were not such as to suggest mixed infection. We feel that this result is little, if any, better than that of ordinary treatment combined with nourishing diet and good hygienic surroundings. J. J. M.

# CLINICAL SURGERY AND SURGICAL PATHOLOGY

In charge of T. H. MANLEY, M. D., New York

## ULTIMATE RESULTS OF CASTRATION IN CASES OF PROSTATIC HYPERTROPHY.

In an editorial article of the May number of the Annals of Surgery Pilcher gives some observations upon the ultimate results as a means of relief for obstructive hypertrophy of the prostate, as follows:

Case 1. Time since castration three years. Present age, 77. Health excellent. Still have five ounces of residual urine, which are withdrawn twice daily by catheter. Urinates spontaneously every two or three hours.

Case 2. Time since operation, two and a half years. Age, 58. Notable improvement in bodily and mental vigor since operation. Had had a greatly over-distended bladder and dribbling urine. Still have 10 ounces residium, and has to use the catheter. Prior to operation there was chronic retention, with 64 ounces in the distended bladder.

Case 3. Time since operation, two and a quarter years. Age, 54. Some residual urine remains, and he continues to have cystitis. Is obliged to use catheter and bladder irrigation. Urination is now more difficult than during the first year after the operation.

Case 4. Time since operation two years. Age, 67. Health excellent. No mention made of the condition of the bladder.

Case 5. Time since operation, one and three-quarters years. Age, 64. In good health and free from all urinary symptoms.

Case 6. Time since operation one and a quarter years. Age, 72. In good health and free from all urinary disturbance.

Case 7. Time since operation, one and a half years. Age, 74 years. In vigorous health. No mention of the condition of the bladder. It is unfortunate that the writer has not made a more detailed report of some of these cases.

In the first part of the article there is recorded another and striking case as follows: The patient, aged 72 years, suffered from obstructive prostatic disease not relievable by catheterization. Suprapubic cystotomy and double vasectomy gave him marked relief and restored the power of voluntary urination. Both results were temporary, however, and at the end of four months obstructive symptoms were again marked. He was then castrated. Gradual amelioration of the urinary symptoms followed, and at the end of four months he was performing the urinary function normally, and was in excellent health again.

—Boston Medical and Surgical Journal.

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## ALTERATIONS IN THE SHAPE OF THE TRACHEA.

Simmonds (Cbl. f. Chirg., March 22, 1898; Jour. of the Am. Med. Ass'n, April 30, 1898.) The author, director at the large hospital at Hamburg, has made a study of casts of tracheas. He found numerous constrictions, dilatations and angularities; scoliosis was noted in one-fourth of all the cases. Constrictions produced by the pressure of aneurisms, tumors and latent goitres were frequent, also a groove, which he attributes to the pressure of the arteria anonyma. The walls were frequently found ossified and flattened in elderly persons, for which he suggests the descriptive name of "senile sabersheath trachea." Universal dilatation was noticed in only one case, probably congenital, but partial ectasia was common, almost invariably in the middle section of the rear wall, in elderly persons, accompanied by atrophy of the wall.

# Current Medical Literature.

## THERAPEUTICS ON LACTO-SOMATOSE.

BY DR. J. P. ZUMBUSCH,

Physician-in-Chief in the German Hospital in London.

Under the above name the Farbenfabriken of Elberfeld have recently introduced into the market an albuminous product consisting of the albumoses of milk, together with 5 per cent. of tannic acid in chemical combination. This remedy appears in the form of a brownish-yellow powder, which is perfectly odorless, and especially free from the so frequently disagreeable odor of similar preparations. It is also rapidly and completely soluble. In preparing the solution, however, it is necessary to follow the directions, and not to simply add the powder to the fluid in which it is to be dissolved, as it is then liable to form a sticky and insoluble mass. On the other hand, if it is first stirred into a smooth paste with cold water it will at once dissolve on the addition of hot water. The solution thus prepared can be readily mixed with beef extract, milk, coffee and numerous other fluids, and may be administered to the patient even without his knowledge, as it is almost tasteless. Even in the form of a simple watery solution, however, Lacto-Somatose was well tolerated by all my patients, and never excited repugnance, even when its use was continued for a long time.

The first experiments with Lacto-Somatose were made in the medical clinic of Professor Schultze, of Bonn, and in the Muenchner Medicinische Wochenschrift, No. 47, 1897, Dr. A. Schmidt reported the results obtained. He prescribed the preparation in daily doses of three teaspoonfuls in chronic affections of the digestive tract, especially in digestive disturbances due to atomy of the muscular coat of the stomach and the intestinal canal, such as occur in enteroptosis and anemic. In this class of patients, who always suffer from loss of apetite, flatulence, constipation alternating with diarrhea, regulation of the state of the bowels in connection with improvement of the other disturbances took place after the use of lacto-somatose. In cases of membranous enteritis and chronic enteritis the stools assumed a normal character, although the patients had been treated previously according to the most diverse methods without success. This product also proved an admirable astringent nutrient in cases of enteritis of tuberculous origin and this is a condition in which a food product is of value which, non-irritating in itself, it adds in the removal of conditions of irritation. Schmidt has further employed lacto-somatose systematically in 15 cases of typhoid, and found that in daily doses of three tablespoonfuls it was well tolerated and diminished the diarrhea to some extent.

I have made use of this remedy especially in surgical practice, and in particular operations upon the gastro-intestinal tract, comprising chiefly herniotomies in adults and children, gastro-enterostomy, and intestinal resection, as well as operations on the vermiform appendix. The administration of lacto-somatose is always commenced, even on the

first day after the operation, and I never observed that the remedy caused vomiting or a feeling of fullness, or enhanced these symptoms when present. As far as I was able to note, the condition of the bowels is never influenced, and above all constipation never occurs, although this might be expected from the presence of tannic acid in this preparation; indeed, in some cases, when administered shortly before meals, lacto-somatose seemed to stimulate the appetite, although this might be attributed to suggestion.

I further employed this preparation in several instances during convalescence from severe diseases of various kinds, and especially in the intestinal diseases of rachitic children. The dose in young children was one-half of that given to adults, namely one-half teaspoonful three times daily, and always administered in milk. Under this treatment the bowels soon became regular, and it is my distinct impression that lacto-somatose exerted a very favorable influence upon the subsequent course of the disease. On the ground of numerous observations I believe therefore that I am warranted in recommending lacto-somatose as a readily digestible and assimilable nutrient in conditions of malnutrition and exhaustions of all kinds.

It certainly fulfills in a high measure the requisite of Leyden of supplying the patient with a sufficiency of food in small quantity.

—Monatschrift fur praklisch Medicin, Heft 7, '98.

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## ALLOUEZ IN DIABETES.

Seven years ago I became afflicted with diabetes mellitus. I tried about everything that I heard of, or read of in the highest medical literature, or that any physician had ever tried, with even a hope that it was helping his patient; but for more than four years I gradually grew worse, until I excreted more than 4000 grains of sugar daily.

In November, 1894, a paralytic condition set in, beginning at the ends of the fingers and toes and extending toward the trunk, one joint at a time, until in about two months I could just stand, and had but slight sensation in my fingers, when I came across one of your booklets. Had no faith in its claims; in fact, said I knew it would not help me, but that was the straw, and so I, the drowning man, caught at it. Strange to say, that in 24 hours after drinking the first glass of Allouez the specific gravity showed only 1019, where it had not been below 1038 for two years, and often as high as 1049, which showed a very critical condition.

From the first day the specific gravity ranged from 1019 to 1024, while the quantity of urine greatly decreased. In less than three months the amount of sugar was down to 200 to 300 grains per day, and occasionally a specimen would show no trace of sugar, by the Haines test.

All thirst, which had been almost unbearable, disappeared after the first week. In five months I could walk as well as ever. In a year the numbness was gone, only when I occasionally overtaxed the members. I am still drinking the water and gaining in flesh, strength and activity. Sugar is still present in traces, but not all the time. Had to diet, of course, and still do.

My paralysis was simply a giving out of the nerve force from mal-nutrition, caused by the loss that should have been supplied by the sugar, had it been assimilated. Thus it first showed itself in the terminal nerves.

There can be no doubt that in three or four months more, without the water, this condition would have reached the vital organs, when death must have ensued, so that I can truly say that Allouez Magnesia Water has rescued me from the jaws of certain death.

I was so bad off I could do nothing only drink the water and watch its effect. I found by trial that the best results were obtained by drinking hot about one-half gallon bottle daily, as follows: One-seventh of it one hour before each meal, one-seventh three-quarters of an hour before each meal, and one-seventh one hour before bedtime.

W. C. GLIDDEN, M. D.,
Beloit, Kan.

# Miscellany.

## THE AMERICAN ELECTRO-THERAPEUTIC ASSOCIATION.

The eighth annual meeting of the American Electro-Therapeutic Association will be held on Tuesday, Wednesday and Thursday, September 13, 14 and 15, 1898, at Buffalo, N. Y.

The Society of Natural Sciences has kindly placed at our disposal its rooms in the Public Library, Lafayette Square; a programme of exceptional interest is assured; there will be an exhibition of electric apparatus for diagnostic, therapeutic and radiographic work; a hand-book of information will shortly be issued by the committee on arrangements. Hotel Iroquois will be the headquarters. Rates, $4 to $5 per day, American plan; $1.50 to $3 European plan.

Among the many entertainments provided there will be tally-ho coach drives about the city daily, a public reception Tuesday night, excursion down Niagara River and reception at Island Club, Grand Island, and other receptions, visits to industries of interest. Extra efforts are being put forth to make this in every way the best meeting that has been held, therefore you are particularly requested to attend. Kindly inform the secretary at as early a date as possible whether you will be present, if you will be accompanied by members of your family and the title of the paper you will read; also the names of persons whom you desire to propose for membership.

An excursion for members, exhibitors and friends from New York to Niagara Falls and return, with stopover privileges at Buffalo, will leave the Hoboken Depot of the Delaware, Lackawanna & Western Railway on Monday morning, September 12, reaching Buffalo about 7 P. M.; a palace car will be attached. Tickets for the excursion, good for 30 days, to return on any regular train of D. L. & W. R. R., $10; seat in palace car, $1.50 extra. Tickets and seats can be secured from Dr. Robert Newman, from whom all particulars may be obtained. Early application should be made, for if a sufficient number can be secured a special train will be run. Special hotel rates at Niagara Falls will be secured for all excursionists.

### PRELIMINARY PROGRAMME.

A series of 10-minute discussions on electrotherapy, of special interest to the general practitioner, including "Effect of Electricity on Tissue Metabolism," "Electro-Diagnosis," "Diseases of the Nervous System," "Diseases of Women," "Genito-Urinary Diseases," "Malignant Growths," "Orthopedic Uses," "Diseases of the Eye," etc.

The following papers have been promised: Dr. Apostoli, Paris, France, "Note on New Applications of the Sinusoidal Current in Electro-Therapeutics;" Dr. Gautier, Paris, (1) "The Hydro-Electric Bath with Sinusoidal Current in Disease," (2) "On the Value of the Hot Air and Light Bath in Disease," (3) "Two Years of Practice in Radiotherapy," (4) "Elec-

trotherapy in Gynecological Applications;" Dr. Felice La Torre, Rome, Italy, "Electricity in the Cure of Uterine Fibromyomata;" Dr. J. Inglis Parsons, London, England, "The Effect of High Tension Discharges upon Micro-Organisms;" Mr. Nikola Tesla, New York, "High Frequency Oscillator for Electro-therapeutic purposes;" Dr. William C. Krauss, Buffalo, "Case of Lightning Stroke Without Serious Consequences;" Dr. Lucien Howe, Buffalo, "The Method for Using Cataphoresis in Certain Forms of Conjunctival Inflammations;" Dr. John O. Roe, Rochester, N. Y., "The Uses of Electricity in Diseases of the Nose and Throat;" Mr. J. J. Carty, E. E., New York, "Cataphoresis;" Dr. J. H. Kellogg, Battle Creek, Mich., "The Electric Light Bath;" Dr. M. A. Cleaves, New York, "Metallic Electrolysis with Laboratory Experiments," (2) Electrical Treatment of Inflammatory Exudates;" "Cataphoresis and Metallic Electrolysis, by William J. Morton, New York; Dr. W. J. Herdman, Ann Arbor, Mich., "Electricity in Gynecology;" Dr. A. D. Rockwell, New York, "Diagnostic and Therapeutic Relation of Electricity to Diseases of the Central Nervous System;" Dr. Grover W. Wende, Buffalo, "Electricity in Acne Vulgaris and Acne Rosaceae;" Dr. Caleb Brown, Sac City, Ia., "Cataphoric Action of the Galvanic Current;" Mr. R. G. Brown, E. E., Brooklyn, (1) "New Electric Light for Diagnostic Purposes," (2) Surface Electrodes, How They Should Be Made; Connector Cords, How They Should Be Made and Insulated;" Dr. Robert Newman, New York, "Electricity in Deafness and Strictures of the Eustachian Tube;" Dr. R. J. Nunn, Savannah, Ga., "Treatment of Uterine Fibroids by Small Currents Administered Percutaneously;" Dr. William F. Robinson, Albany, N. Y., "Treatment of Certain Muscular Affections by Means of Electricity;" Dr. G. W. Overall, Memphis, Tenn., "True Status of Electricity and Allied Remedies in Treatment of Strictures and Prostatitis;" Dr. W. S. Watson, Fishkill-on-Hudson, N. Y., "Electricity and Medical Institutions;" Dr. W. H. White, Boston, Mass., "Static Electricity in Nervous Diseases;" Dr. H. S. Jewitt, Dayton, O., "The Misuse or Abuse of Electricity as a Therapeutic Agent;" Dr. W. Scheppegrell, New Orleans, La., "Electricity in Diagnosis of Disease of the Ear; "X-Ray Burns," by Dr. W. H. Harris, Toronto, Ont.

An illustrated lecture on the X-ray will be delivered by Dr. William J. Morton, New York.

An exhibition of electrical apparatus for diagnostic, therapeutic and radiographic purposes will be held in the same building.

A cordial invitation is extended to members of the profession.

CHAS. R. DICKSON, M. D., President.
JOHN GERIN, M. D., Secretary.

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## THE TWENTY-FOURTH ANNUAL MEETING OF THE MISSISSIPPI VALLEY MEDICAL ASSOCIATION WILL BE HELD AT NASHVILLE, TENN., OCTOBER 11-14, UNDER THE PRESIDENCY OF DR. JOHN YOUNG BROWN, OF ST. LOUIS, MO.

This association is second in size only to the American Medical Association and has done most excellent scientific work in the past. The annual addresses will be made by Dr. James T. Whittaker, of Cincinnati, on "Medicine," and by Dr. George Ben Johnson, of Richmond, Va., on "Surgery." The mere mention of the names of these gentlemen establishes the fact that the association will hear two scholarly and scientific addresses.

Nashville is a most excellent convention city and is well equipped with hotels, and with the record of the meeting in Louisville in 1897 as an example the local profession under the leadership of Dr. Duncan Eve as chairman of the committee of arrangements has prepared to have a better meeting.

Already titles of papers are being received. These should be sent to the secretary, Dr. Henry E. Tuley, 111 West Kentucky street, Louisville, Ky., as early as possible to insure a good place upon the program. Reduced rates on all railroads will be granted on the certificate plan.

FALL AND WINTER SCHEDULE OF CLINICS. 1898-1899.

## NEW YORK SCHOOL OF CLINICAL MEDICINE, 328 West 42nd St., bet. Eighth and Ninth Aves.

| HOURS | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | ROOM |
|---|---|---|---|---|---|---|---|
| A. M. 9–10 | **SURGERY** Dr. Pfister | **SURGERY** Prof. Manley | **SURGERY** Dr. Pfister | **SURGERY** Prof. Manley | **SURGERY** Dr. Pfister | **SURGERY** Prof. Manley | 1–2 |
| 10.30–12 | | **INTERNAL** Prof. Morrissey | | **INTERNAL** Prof. Morrissey | | **INTERNAL** Prof. Morrissey | 17 |
| 10–12 | | **GENIT. URIN** Prof. Valentine | **WOMAN** Prof. Collyer | **GENIT. URIN: Sat.** Prof. Valentine | | **WOMAN** Prof. Valentine Prof. Collyer | 10 14–16 |
| P. M. 2–3 | **CHILDREN** Prof. Dessau | **CHILDREN** Prof. Fischer or Ass't | **CHILDREN** Prof. Dessau | **CHILDREN** Prof. Fischer or Ass't | **CHILDREN** Prof. Dessau | **CHILDREN** Prof. Fischer or Ass't | 12 |
| 2–3 | **NERVOUS** Dr. Lichtschein | | **NERVOUS** Dr. Lichtschein | | **NERVOUS** Dr. Lichtschein | | 3 |
| 3–4 | **GENIT. URIN** Dr. Lowenstein | | **GENIT. URIN** Dr. Lowenstein | | **GENIT. URIN** Dr. Lowenstein | | 10 |
| 3–4 | **SKIN** Prof. Gottheil | | **SKIN** Prof. Gottheil | | **SKIN** Prof. Gottheil | | 10 |
| 3–4 | **INTERNAL** Dr. Cahen | | **INTERNAL** Dr. Cahen | | **INTERNAL** Dr. Cahen | | 17 |
| 3–4 | **EYE and EAR** Dr. Meek | **EYE and EAR** Dr. Denig | **EYE and EAR** Dr. Meek | **EYE and EAR** Dr. Denig | **EYE and EAR** Dr. Meek | **EYE and EAR** Dr. Denig | 18 |
| 3–4 | **WOMAN** Prof. Goelet | **WOMAN** Prof. Collyer | | **WOMAN** Prof. Goelet | **WOMAN** Prof. Collyer | | 14–16 |
| 2.30–3.30 | **SURGERY** Dr. Levin | **SURGERY** Dr. Garrigues, Jr. | **SURGERY** Dr. Levin | **SURGERY** Dr. Garrigues, Jr. | **SURGERY** Dr. Levin | **SURGERY** Dr. Garrigues, Jr. | 1–2 |
| 4–5 | **THROAT and NOSE** Dr. Hatch | **THROAT and NOSE** Dr. Schwerd | **THROAT and NOSE** Dr. Hatch | **THROAT and NOSE** Dr. Schwerd | **THROAT and NOSE** Dr. Hatch | **THROAT and NOSE** Dr. Schwerd | 3 |

## At the GERMAN POLIKLINIK, 78 and 80 Seventh St., bet. Second and First Aves.

| HOURS | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY | ROOM |
|---|---|---|---|---|---|---|---|
| P. M. 3 | **LARYNGOLOGY Rhinology-Otology** Prof. Busche | | | **LARYNGOLOGY Rhinology Otology** Prof. Busche | | | |
| 1.30–3.30 | | | **PEDISTRICS** Prof. Fischer | | | **PEDISTRICS** Prof. Fischer | |
| 2–3 | **EYE and EAR** Dr. Denig | | **EYE and EAR** Dr. Denig | | **EYE and EAR** Dr. Denig | | |
| 3–4 | **INTERNAL** Medicine | | **INTERNAL** Medicine | | **INTERNAL** Medicine | | |
| 4–5 | | **SURGERY** | | **SURGERY** | | **SURGERY** | |